Health and Welfare Canada
Santé et Bien-être social Canada

# Issues and Priorities for Women's Health in Canada: A Key Informant Survey

Canada

# ISSUES AND PRIORITIES FOR WOMEN'S HEALTH IN CANADA

## A KEY INFORMANT SURVEY

HEALTH PROMOTION DIRECTORATE

HEALTH AND WELFARE CANADA

OTTAWA

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## FOREWORD

This report describes the findings of a survey of Canadian experts on women's health, undertaken in the summer of 1986 as part of the Women's Health Strategy Project of the Health Promotion Directorate, Health and Welfare Canada.

It is intended as a factual presentation of concerns related to women's health that were identified by the informants. These findings will be used in the future to develop health policies and programs for women.

I wish to acknowledge the commitment and dedication of the five members of the Health Promotion Directorate who assisted me with the interviews: Susan Dann, Susan Garceau, Jessica Hill, Rita Stern and Evelyne Vallée. Others involved in the conceptualization and planning of the project included Joan Johnston and Karen Madden, as well as staff in the Directorate regional offices.

Thanks are also due to the fifty-three women who participated as expert informants. Their willing co-operation and enthusiasm inspired the project team.

Eleanor Thomas
Co-ordinator
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## INTRODUCTION

The Health Promotion Directorate (HPD) of Health and Welfare Canada has undertaken women's health projects since 1978. In 1983, women's health was formally identified as a distinct program area, and a list of priorities and projects for the next five years was tentatively approved. In 1984, the committee responsible for planning and co-ordinating women's health activities identified a need for an integrated program plan with long-term goals and strategies. As a result, the Women's Health Strategy Project was developed. The purpose of the project was to prepare a strategy paper on women's health for the Directorate, and to recommend a long-term program plan.

The Women's Health Strategy Project includes four phases: 1) a review of the literature on women's health, and a survey of existing resources, policies and programs, to guide the development of a framework for the project; 2) consultation with key experts on women's health to increase understanding of relevant issues, factors and needed changes; 3) shaping of strategy and program ideas through discussion with women in the general public; and 4) integration of all findings into a background paper, with recommended strategies and long-term program options for promoting women's health in Canada.

The literature and resource reviews were completed in the summer of 1985, after which the expert consultation was planned. The consultation phase of the project was designed as a key informant survey, and was undertaken in the summer of 1986. From May to September, 44 interviews were completed with 53 experts on women's health from across Canada. This report presents the findings of that survey.

## METHOD

### A. Data Collection

A structured interview format was chosen for the survey to ensure comparability among responses while allowing the broadest possible range of ideas and opinions to be elicited from the informants.

The interview protocol was designed to gather ideas and information in six areas: key health issues and problems for women; factors underlying women's health issues; important target groups; changes needed to improve women's health; priorities for the federal government; and existing health programs and activities for women. In addition, background information was requested on the current and past involvement of respondents with women's health activities. A basic framework for possible responses to some of the questions, which was derived from the literature survey, was provided to interviewers to help guide their recording of responses and, where necessary, their probing for further information. Responses were hand recorded by the interviewers directly onto the interview protocols. A copy of the interview protocol appears in Appendix 1.

Interviewers included six members of the Women's Health Committee of the Health Promotion Directorate, all of whom had been involved in the planning and development of the project, and who were knowledgeable in the area of women's health.

### B. Interviewees

Interviews were conducted with a sample of experts on women's health throughout Canada. Experts were selected from community, academic, medical and government settings, with most having considerable community experience. The sample was selected to include a few with expertise on women in specific situations such as rural, immigrant and minority, poor and disabled women. In addition each of the five regions of Canada was represented.

A list of over 200 possible key informants was identified using a variety of information sources, including: women's health literature; conferences and workshops on health and women's issues; university sources; expert government sources, including H.P.D. regional offices; status of women agencies; and women's health groups. From this master list, a selection of approximately 50 interviewees was made in consultation with the Women's Health Committee of H.P.D. The selection took into account the settings and areas of specific knowledge noted above, as well as the credibility and degree of expertise of the identified individuals.

A small number of the initial list of informants were unavailable, and one declined to be involved because she felt she lacked the required expertise. The final sample included 53 informants, 38 of whom were interviewed individually. Forty-four separate interviews were undertaken, six of them involving more than one informant. The number of interviews per region was as follows: Western region (B.C. and Alberta): 9; Prairie region

(Saskatchewan and Manitoba): 8; Ontario: 10; Quebec: 9; Atlantic region (New Brunswick, Nova Scotia, Newfoundland): 8.

C. Interviews

An initial contact letter was mailed to all the selected informants, briefly describing the survey and inviting their participation. This was followed by a telephone call from the interviewer to give more information about the project, obtain their agreement to participate, and make initial arrangements for the interviews. Documents describing the project and providing background information about H.P.D. and its activities in women's health were then mailed out prior to the interview.

The interviews were conducted between May and September 1986.

D. Analysis

Analysis of the data was largely qualitative and necessarily somewhat subjective.

An initial scan of the completed protocols identified themes and consistencies in the interviews. These were used to develop a preliminary framework for categorizing and counting responses to the six interview questions.

Each of the interview protocols was studied in detail, responses were categorized where appropriate, and response categories or specific responses were recorded using the framework. Finally, the results were tabulated by question, as presented in the tables in Appendix 2.

## RESULTS AND DISCUSSION

### The Tables

The major findings of the survey are presented in Tables I to VI-E (Appendix 2).

These tables summarize the responses given to questions 4, 5, 6, 7 or 8, and 9 and 11 of the questionnaire. Responses have been grouped into categories, and counts have been given of specific responses, and of response categories, where appropriate. The counts tell the number of interviews in which a particular item or category was raised as important by the interviewees.

The numbers are included in the tables to provide a rough indication of the extent of concern among women's health experts about different issues, factors and priorities. They should not be interpreted as rankings of importance in any kind of absolute way. Rather, they simply give a feel for the current focus of concern. Qualitative research of this type is intended to provide guidelines and focuses for policies and programs, rather than hard numerical conclusions about the significance of various issues. For this reason, the following discussion of the findings concentrates on highlights and themes, rather than on assigning priority to items.

Table I presents the key health problems and issues for women identified by the respondents.

Table II presents factors that underlie and contribute to these issues.

Table III lists subgroups of women who were identified as being at special risk for health problems, and Table IV gives the key health issues and factors raised as important to them.

Table V deals with factors that have a positive effect on women's health.

Tables VI-A to VI-E present needed changes and priorities for action in five spheres: health programs and projects; medical and health services; social and economic policy; research; and regulations and legislation.

Each of these tables is further described in the following pages.

### Discussion of Findings

#### I Key Health Issues for Women

Table I presents the key health problems and issues for women identified by the informants. The health issues fall into six response

categories: issues related to mental health; violence against women; reproductive health; reproductive disorders; nutrition and fitness; and chronic medical conditions.

A. Mental health and related issues were identified as important by almost all of the respondents. Stress and substance use, especially use of prescribed drugs, were considered particularly significant.

In 36 of the 44 interviews specific reference was made to women's mental health as a key issue area, including stress and anxiety (26 references), depression (13), mental health problems in general (13), and low self-esteem (11).

Substance use issues included concerns about overuse of and addiction to prescribed drugs (26), tobacco (20), and alcohol (17).

Other mental health issues raised centered on sexuality and sexual expression (14) and problems related to body image (16), including eating disorders (11).

B. Violence against women was an issue of concern to a high proportion of respondents (29 of 44). Wife abuse (13), incest (11), and rape (6) were among the specific issues raised.

C. Reproductive health issues were the focus of concern for many of the experts consulted. Contraception, abortion, pregnancy and childbirth, and menopause were key topics.

The need for safe, effective contraception was emphasized by 27 of the respondents. Related to this issue were health and safety concerns about specific contraceptive drugs, devices and surgical procedures now favoured by medical experts, to the exclusion of lower technology approaches.

Choice about reproduction was another dominant theme in the interviews, with problems related to access to abortion services being identified by 25 respondents.

Pregnancy and childbirth was identified by 24 experts as a lifestage that generates physical and emotional problems for women, largely as a result of medicalization of the process.

Most of the concerns related to menopause (21 references) centered on medical involvement in this lifestage, including the potentially harmful use of hormone therapy to deal with problems (6), and unnecessary hysterectomy (8) to which women are frequently subjected.

Several other issues related to reproductive health were raised by a significant number of informants. Problems arising from new reproductive technologies, especially those related to fertility problems, concerned many

of the experts (15), as did apparently increasing rates of infertility (10). Unwanted teenage pregnancy and associated problems (15), and premenstrual syndrome (8) were other concerns.

D. Reproductive disorders of concern included high rates of pelvic inflammatory disease (9) and related infertility, sexually transmitted diseases (6); and other medical conditions.

E. Occupational and environmental health issues were raised by many respondents. Physical health and safety in the workplace (18), workplace pressure on women workers (8), and problems caused by polluted and otherwise unhealthy living environments (15) were mentioned.

F. Nutrition and fitness were raised as problems for women by 15 informants. Inadequate diets (10), lack of exercise (9), and obesity (5) were among the concerns given.

G. Chronic medical conditions affecting women were raised as concerns by a few of the interviewees. Osteoporosis (5), breast cancer (3), and other breast health issues (3) were among the conditions mentioned.

## II Factors Underlying Women's Health Issues

Informants were asked what they believed to be the factors and situations in our society that have the most serious negative impacts on women's physical and mental well-being. Table II summarizes their responses to this question. The factors they identified fell into five major response categories: attitudes and practices of medical institutions; access to appropriate medical and health services; women's roles and relationships; the economic status of women; and occupational and environmental conditions.

### A. Attitudes and practices of medical institutions

1. Medical attitudes to women that are harmful to their well-being was a factor identified by many informants. Almost half of all the respondents (20) referred to harmful attitudes in a general way. Specific attitudes mentioned included the belief that medical practitioners do not recognize women's competence to understand or deal with their health problems (12), and that women's normal life stages are perceived by many doctors as medical problems requiring intervention (11). Insensitivity to women's needs (9), medicalization of women's social problems (8), and the perception of males as normal and females by contrast as deviant (8) were other attitudes of concern. Medical training, medical literature, and drug companies were seen to both inspire and maintain these attitudes (12).

2. Medical control of and intervention in healthy processes was a significant concern. Medical intervention was identified by 20 respondents, and included intervention in childbirth, reproductive life stages and contraception. Contributing to this was women's powerlessness and lack of control regarding their own health (15).

3. Medical focus on technology in research, prevention and treatment was mentioned by a large number of informants (29). Included as specific concerns were the overprescription of drugs (16), technology related to all aspects of reproduction, and unnecessary surgery. A lack of medical interest in prevention was also raised.

### B. Access to appropriate medical and health services

1. Barriers to traditional medical services were seen as an important factor by many experts (25). Many were concerned about administrative and political barriers to abortion services (14). Geographic barriers (9) were a concern, particularly for those with expertise on the health of women living in more remote areas. Financial barriers to medical supplies, drugs and devices, and uninsured services (8) were another concern, especially for low-income women.

2. Lack of access to and availability of alternative, non-traditional health services was one of the most important factors affecting women's health, according to informants, with 28 raising this concern. Many referred to the lack of alternatives in a general way (19), while others referred specifically to alternative birthing services (16)

including availability of midwives (14). Other alternative services and caregivers were also cited, as indicated in the table.

C. Women's roles and relationships

Both attitudes to women's roles and relationships and the nature of these roles were discussed by informants as significant health factors.

1. Attitudes to women's roles and relationships of concern included attitudes undervaluing women's traditional roles (15 respondents). Among the specific examples given were the low status of housewives (11) and the undervaluing of traditional women's employment (6).

Many women raised the question of the stereotyping of women's roles and relationships, including the nature of the stereotypes themselves and the processes maintaining them. They were concerned about society's prescriptive expectations of women's role in the home (13), including the social isolation (13), economic dependence (10), social dependence (9), and role conflicts (7) that arise from them. Prescriptive expectations regarding women's employment and education were also a factor (10). The socialization of girls towards dependence and subordination (10) within the mass media (8), religious and other conservative organizations (6), and the education system (5) were seen as processes supporting these stereotypes.

Harmful attitudes and practices related to women's sexuality (12) and women's bodies (10) were other problems mentioned.

2. Factors related to the nature of women's roles included concerns about the heavy responsibility loads experienced by women. Women's responsibility for child raising (21), and their responsibility for caring for the health and well-being of their families and others (20) were seen as key factors affecting women's health. The double workloads of employed women was also a major issue (15).

Linked to the question of heavy responsibility levels was concern about the lack of support for those roles. Lack of affordable day care (17) and inadequate social support for caregiving in the home (9) were among the specific problems raised.

D. Economic status of women

The most frequently mentioned of all the factors affecting women's health was poverty and economic insecurity, raised in 30 of the 44 interviews. Sources of women's economic problems included low pay and inadequate benefits (13) and the marginality of women's jobs (13), as well as income support problems.

E. Occupational and environmental conditions

Negative social factors in the workplace, unhealthy physical work situations, and unhealthy physical living environments were other factors raised by informants, as follows:

1. Negative social factors in the workplace included discrimination against women at work (12), workplace pressure (8), and powerlessness in women's jobs (8) among others.

2. Unhealthy physical work environments were mentioned by 19 respondents.

3. Unhealthy physical living environments (15) including environmental pollution (10) was another important concern.

## III Groups at Special Risk

Informants were asked what groups of women in our society were particularly at risk for health problems, and what the key health issues and underlying factors were for them.

Table III presents the number of informants indicating different age, economic, ethnic, geographic, and other special groups as being of special concern. Among the groups mentioned most often were elderly women (25), poor women (24), immigrant and minority women (22), teenagers (20), native women (19), disabled women (15), isolated and rural women (14), and women in midlife (12). Other groups are listed in the table.

In interpreting these results, and the findings in Table IV, it should be remembered that respondents were selected for the most part for their general expertise on women's health issues. A small number however, were included because of their specific knowledge of and experience with special groups. The figures in Table III reflect the varying expertise of the respondents and the pattern of their concern, but should not be interpreted as indicating that one sub-group is more important or has more serious health problems than any other.

## IV Vulnerable Groups: Key Health Issues and Underlying Factors

Table IV presents the key health issues and underlying factors identified for groups at special risk.

### A. Age Groups

Teenagers and young women were mentioned by 20 respondents. Unwanted pregnancy (15) was the major issue for this group, while mental health problems (9) and substance use (16) were also considered significant. A variety of underlying factors were raised.

For women in midlife, mentioned by 12 respondents, 3 of whom had special knowledge and expertise with this group, mental health problems (7) and issues related to menopause (6) were key concerns. Among the factors contributing to these problems were negative social attitudes towards midlife women (6), heavy family responsibility loads including elderly parents and children (4), and family changes (4). In addition, harmful medical attitudes (4) and medicalization of menopause (4) were concerns.

Elderly women, identified as a vulnerable group by 25 informants, were seen as being especially at risk for mental health problems (10). Inadequate nutrition (4) was among other concerns raised. Factors underlying health problems included social, medical and economic factors. Isolation and loneliness (13) was a major item, as was harmful social attitudes to aging and the elderly (10). The overprescription of drugs to older women (10) and harmful medical attitudes to aging (4) were medical factors raised, while poverty (6) among elderly women was seen as another key factor undermining well-being.

B. Economic Groups

While poverty was a health factor raised for almost all of the vulnerable groups listed, 24 of the respondents talked about poor women, including single parents and low-income workers, as a major group on which concern should be focussed. Mental health problems (9), especially stress (8); poor nutrition (9); and work-related problems were among the issues raised. All respondents indicated that the lack of access to goods and services implied by poverty seriously undermined the health and well-being of poor women. Lack of access to medical services (6), overwork and responsibility overload (6), and exposure to pollution (4) were among other factors raised.

C. Ethnic Groups

Immigrant and minority women were identified in 22 interviews, two of which included respondents with special knowledge of this group. Mental health issues were emphasized (4), and family violence was also a concern. Factors underlying health problems for this group centered on language barriers (8) and cultural conflicts (8). Medical (5) and social (4) attitudes to immigrants, and unhealthy work conditions (4) were other factors.

Native women (19) have health problems related to alcohol (9) and drug (4) use. Wife abuse (6) is another issue raised for this group. Major factors underlying health problems were related to access issues, including lack of access to medical services (6), health and social services (5), and basic goods and services (food, water, housing, etc.) (4). Harmful social attitudes to native women (4) was another factor raised. Most of the issues and factors identified for geographically isolated groups also apply to native women.

D. Geographic Groups

Women in rural and geographically isolated locations were identified by 14 respondents (five of which have special expertise in these areas) as being at special risk. Mental health (6), especially stress (6), and alcohol (4) and drug use (3) were raised as specific problems. Responses focussed on factors affecting the health of isolated and rural women rather than on health problems per se. Access to health and social services (12), including alternative health care (6), social support services (5) and day care (4), was a significant factor, as was access to traditional medical services (8). Isolation at home (6), access to transportation (4), and the current economic crisis in agriculture (4) were among other harmful factors identified.

E. Special Groups

Disabled women were recognized as a high-risk group by 15 informants, two of whom had relevant expert knowledge and experience. Mental health (6) was the major issue area for this group, with an emphasis on stress (3). Violence (2) was another important concern. Harmful medical attitudes toward disabled women (6) and inappropriate care (5) as a result of these attitudes

were significant factors. Social factors including societal attitudes (4), and powerlessness and dependency (2) were cited as were continuing problems with physical access to public places (3), including medical services.

F. Other Groups

For low literacy women (18), access to medical care and information (5) was the key issue. Isolation (4) was identified as a harmful health factor for housewives (5), while lesbian women (4) were thought to experience problems as a result of harmful societal and medical attitudes (3). Other groups of concern are listed in the table.

## V Positive Factors That Facilitate Health

Informants were asked about factors and situations in our society that have important positive impacts on women's physical and mental well-being. Table V presents their responses to this question. Positive factors fall into seven response categories. The three most significant categories were: positive changes in societal attitudes and practices towards women; the trend towards self-help and self-care in health; and the growth of women's organizations and activities. Other response categories included: improved medical care and alternative health services; certain specific health promotion programs and projects; improvements in social services; and improvements in social conditions.

### 1. Positive changes in societal attitudes and practices towards women

An increased sharing by women and increased contact among them in recent years was identified as a major health facilitator by 16 informants. An increased awareness of options and choices for and by women (11) and an increased awareness and legitimization of women's issues (8) were also seen as valuable. In addition, societal recognition of women's culture and values (6) and of the need for equality with men (6) were recognized as positive developments for women's health.

### 2. Trend towards self-help and self-care

Women's increased interest in self-help and self-care (10), leading to increased knowledge of their own bodies and their own health (10) was identified as an important health facilitator.

### 3. Growth of women's organizations and activities

Feminism and the growth of the women's movement was thought to have had significant positive impacts on women's well-being as expressed by 17 respondents. The growth of women's health collectives and networks (12), women's self-help groups (8), and other women's organizations were reported as positive factors of note.

### 4. Improved medical care and alternative health services

Among the positive changes noted in this response category were improved contraception (8) and the establishment in a few locations of women's health centres and community clinics (5).

### 5. Health promotion programs

PARTICIPaction (14) and government anti-smoking campaigns (4) were seen as having had a positive impact on women's health. Various specific Health Promotion Directorate projects were also mentioned.

### 6. Improved social services

Where social services such as day care, shelters for battered women, and others had been established, they were seen as being positive contributors to health and well-being (7).

### 7. Improved social conditions

Certain changes in social conditions in Canada were mentioned as positive by a few respondents.

## VI Changes and Priorities

Informants were asked what changes were needed in programs, services, legislation, or any other areas to bring about improvements in the health and well-being of women. They were also asked what they believed the priorities of the federal government should be for action on women's health. The responses to these two questions have been amalgamated for analysis because of the considerable overlap between them. The responses are presented in Tables VI-A to VI-E.

The informants tended to discuss needed changes and priorities in five different spheres: health programs and projects; medical and health services; social and economic policy; health research; and regulations and legislation affecting women's health.

### A. Changes and Priorities: Health Programs and Projects

1. Policies for health programs. Many respondents identified a need for changes in the overall policies guiding health programs for women at all levels. Key policy changes recommended included a major shift in focus towards wellness, promotion and prevention and away from disease, treatment and illness (19). The need to give priority to empowering women to take responsibility for their own health (18) was another significant recommendation. Policies that emphasized supporting activities by women for women (10), and a focus on eliminating barriers to women's health programs, including financial, social, cultural, geographic and physical barriers, were other significant recommendations.

2. Strategies for health programs. Informants offered several recommendations for changes in strategies for and approaches to women's health programs. The need for stable, long-term core funding for women's groups working on activities related to women's health was emphasized by 14 respondents. The involvement of women and women's groups in the planning of health programs from the start (12) was another significant change recommended. Many respondents, recognizing limitations on the federal government's role in health, stressed that a leadership role should be taken and pressure applied to provincial governments to get them to adopt policies and programs supportive of women's health (10). The need to increase dissemination of effective women's health programs (10), to encourage consumerism towards medical and health care by women (9), to support community-based, grassroots activities (9), and to support advocacy and lobby groups working for positive changes for women (7) were other strategies identified. Several women called for a strengthening of the role of Health and Welfare Canada in promoting women's health including the development of a strong women's program within the Health Promotion Directorate (6).

3. Kinds of programs. Several types of programs and projects were identified by informants as being especially valuable and needed. These included health information programs that increase the availability of health information for women (19), programs supporting women's self-help groups (18), development of resource materials and support of other activities appropriate

for specific groups of women (13), and support for networking and information-sharing activities (7).

4. Specific program needs. Many respondents offered examples of specific program and project needs. Among topics identified for increased attention were: information for women about the medical system and how to deal with it (10), sexuality (9), parenting (6) and information on various reproductive issues (14) including STDs (6), contraception (5) and new reproductive technologies (5) among others. Specific projects identified as needs included development and support of a national women's health network, recommended by 14 respondents, and the creation of national or regional clearing houses on women's health (10). Several saw these activities as linked. The related need for a national non-governmental lobby and watchdog group on women's health issues was also raised (2). Other interesting project ideas proposed by one or a few women included regional information hot lines (800 system) on women's health issues; use of the technology and distribution system of the video industry to communicate health information, especially to teenagers; development of a response system to counter media misinformation directly; provision of information to women on regulations and legislation that are relevant to health and use of shopping malls and storefronts as highly accessible information distribution centres.

B. Changes and Priorities: Medical and Health Services

1. Policies for medical services. Recommended changes in policies guiding medical services were consistent with medical system factors that were identified as having significant negative impacts on women's health (section IIA), focussing on a) medical attitudes and practices, and b) access to appropriate services. Respondents called on governments and other agencies to recognize the need to reduce medical power and increase consumer control of services (16). They recommended changing the focus of medical services away from high technology interventions and towards prevention (16). The need for changes in medical attitudes towards women was also identified (7). A strong and consistent theme throughout the interviews was the recognition that the existing medical system fails to meet women's needs. A major recommendation, offered at some level by 35 of the 44 interviewees, was that priority be given to developing and ensuring access to alternative health services and practitioners for women. Another important recommendation called for the elimination of barriers to traditional medical services, including financial, social, cultural, geographic and physical barriers (20).

2. Strategies for medical services. Among the strategies recommended for improving the effectiveness of health services for women was a consistent call for governments to recognize, legitimize and fund alternative health services and practitioners (26), including establishing health insurance funding for them (14). Developing traditional and alternative services for special groups was also proposed, with the understanding that pressure should be used by the federal government to encourage provincial governments to implement some of the recommended changes. Other strategies

included supporting education for doctors about prevention, women's health, and community services (10), encouraging more women to become involved in medical care (9); and enforcing bans on extra-billing (7), among others.

3. Specific service needs. Informants identified specific services that were needed by women. These were consistent with issues and factors identified earlier. The need for access to abortion services for all women was identified by 26 informants. Alternative birthing services were called for by 20 respondents including midwife services (16). A specific need for women's health centres, separate from traditional medical facilities, was another key recommendation (15). Other service needs included women's addiction treatment services (8); services dealing with violence against women (8); counselling services for women (6); and community clinics for traditional medical care (6).

## C. Changes and Priorities: Social and Economic Policy

Several informants identified needed changes in social and economic policies and programs to deal with the negative factors they had mentioned that undermine women's health.

Access to good quality child care for all women who need it was a major recommendation (15). Economic policies that lead to economic security for women were recommended by 14 informants, with specific mention of income support for families (6), a guaranteed minimum wage for all (4), and adequate pensions for women (3). Improvements in work benefits that recognize parental roles and family responsibilities (8); an increase in priority for social services supporting women in their caregiving roles (8); and policies recognizing the value of women's work in the home (7), were related policy recommendations. Various other policy recommendations appear in the table.

## D. Changes and Priorities: Research

A few respondents called for changes in research policy including an increase in research on women's health and health needs (8); support of research on women by women (6); increased consumer input on research funding decisions (4); and better dissemination of research findings relevant to women's health (3). Among the issues needing increased research activity were safe, low technology contraception (7); and the causes and prevention of infertility (5). Others appear in the table.

## E. Changes and Priorities: Regulations and Legislation

Changes in regulations and legislation affecting women's health were wanted by several respondents. Some called for more consumer input in the development of regulations and legislation through working groups and other means (6). Consistent with issues and factors identified earlier, several informants called for liberalization of the abortion laws and their implementation to ensure access for all women (11). Modification of regulations to allow the practice of midwifery (7) and strengthening of drug and product testing rules (6) were among other changes, as noted in the table.

**WOMEN'S HEALTH PROJECT**

**INTERVIEW PROTOCOL**

A. Background Information

1. Confirm personal details

   Name:

   Address:

   Phone:

2. Confirm paid or unpaid work:

   Current position:
   Organization:

   Relevant volunteer activities:

3. Ask for a brief summary of respondent's past and present activities around women's health and social issues:

B. Problems and Issues

We would like to identify current major concerns related to women's health and well-being, both mental and physical.

4. What do you think are the most important health problems or issues for women at the present time?

Interviewer: Try to get issues within at least 4 of the following 6 areas.

Mental health

e.g. stress, anxiety
depression
insomnia
low self-esteem

Reproductive health

e.g. pregnancy
childbirth
contraception
technology
sexuality
menopause

Reproductive disorders

e.g. PMS
STDs
PID and infertility
vaginal infections

Drug use

e.g. tranquillizers
anti-depressants
alcohol abuse
tobacco

Safety

e.g. violence
occupational health

Chronic conditions

e.g. arthritis/rheumatism
back problems
headache
osteoporosis
psychiatric disorders
breast cancer
cardiovascular disease
obesity

## C. Factors Underlying Health

Women's health and well-being is affected by their physical make-up, by their behaviour, and their physical environment. It is also affected by the social environment in which they live. This refers to factors like how society views women, women's roles, women's work and other factors.

5. In your opinion, what are the factors and situations in our society that have the most serious negative impacts on women's well-being, both physical and mental?

Interviewer: Try to get comments within at least 2 of the following 4 areas.

**Medical system**

e.g. attitudes to women
overprescribing
unnecessary surgery
intervention in childbirth
control of contraception
lack of alternatives
double workloads

**Roles and relationships**

e.g. low status of housewives
isolation at home
dependence, subordination
parenting responsibility
caregiver responsibility
attitudes to sexuality
and sexual expression

**Workplace**

e.g. access to jobs
day care
attitudes to women at work
work conditions
pay and benefits

**Economic status**

e.g. poverty
economic insecurity
pensions for women
income support - elderly
income support - family

6. What about factors that facilitate health: What are the factors and situations in our society that have the most important positive impacts on women's well-being, both physical and mental?

D. Vulnerable Groups

Interviewer: Ask either question 7 or question 8, but not both. Question 7 is intended for respondents who are known to have particular target group expertise, while question 8 is for those with more general experience. If respondents with particular expertise have already answered previous questions in terms of their specific target group, do not ask question 7 or 8, but move on to question 9.

7. (Optional) Your own activities have centered around
   (immigrant women)
   (isolated rural women)
   (poor women)
   (disabled women)
   (other)

   What are the key health issues for them?

8. (Optional) Are you aware of groups of women in our society who are particularly at risk for health problems? If so, who are these groups, and what are the key health issues for them?

   Interviewer: The following examples may be helpful as a checklist. A single response to this question is acceptable.

| | |
|---|---|
| immigrant | poor |
| minority status | single mothers |
| native | elderly |
| rural isolated | midlife |
| disabled | homemakers |
| lesbian | industrial workers |

E. Needed Changes

We've talked about health issues, about factors underlying health and well-being, and about groups at special risk of problems. The focus of the next question is on changes that are needed to bring about improvements in women's well-being. For example, there could be changes needed in legislation, or in programs and services, or maybe in available resource materials, and so on.

9. In your opinion, what are some of the changes in these or any other areas that would lead to improvements in the health and well-being of women?

F. Activities

We are trying to get a broad picture of what is going on now around the country in relation to women's health. To do that, we are asking people about activities in their own locality, or farther afield, that are intended to improve the well-being of women.

10. Could you tell me what you are aware of in the way of programs, groups, networks, resources, and so on, (in addition to the activities you have already mentioned) in your region or in Canada as a whole?

G. Federal Government Priorities

The last question relates to priorities for action on women's health by the federal government.

Health is mainly the responsibility of the provincial governments, and almost all health and medical services fall under provincial jurisdiction. However, the federal government continues to play an important role in health. That role includes coordination, communication, and leadership on new issues.

11. Within that context, what do you believe the priorities of the federal government should be for action on women's health issues?

H. Other Comments

12. Is there anything you would like to add?

## List of Tables


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## TABLE I: KEY HEALTH ISSUES FOR WOMEN

### A. Issues Related to Mental Health

#### 1. Mental Health

| | | | |
|---|---|---|---|
| - all references to mental health | | | 36 |
| - general references to mental health | 13 | | |
| - stress, anxiety | 26 | | |
| - depression | 13 | | |
| - low self-esteem | 11 | | |

#### 2. Substance Use

| | | | |
|---|---|---|---|
| - general references to use, addictions | 3 | | |
| - alcohol use/addiction | | | 17 |
| - tobacco use | | | 20 |
| - drug use/addiction | | | |
| o all references to drug use/addiction | | | 26 |
| o general references to drug use and addiction | 10 | | |
| o general references to prescribed drugs | | 20 | |
| o prescribed drugs | | | |
| - all references to prescribed drugs | 11 | | |
| - prescribed psychotropics | 11 | | |
| o illicit drugs | 2 | | |
| o multiple use | 1 | | |

#### 3. Sexuality

| | | | |
|---|---|---|---|
| - all references to sexuality | | | 14 |
| - general references to sexuality | 13 | | |
| - sexual problems, dysfunction, negative attitudes | 6 | | |

#### 4. Body Image

| | | | |
|---|---|---|---|
| - all references to body image problems | | | 16 |
| - general references to body image | 12 | | |
| - eating disorders | 11 | | |

### B. Violence Against Women

| | | | |
|---|---|---|---|
| - all references to violence | | | 29 |
| - general references to violence | 16 | | |
| - wife abuse | 13 | | |
| - rape/sexual assault | 6 | | |
| - incest | 11 | | |
| - fear of violence | 3 | | |
| - sexual abuse of patients | 2 | | |
| - verbal assault | 1 | | |

C. Reproductive Health

| | | | |
|---|---|---|---|
| 1. medicalization of pregnancy and childbirth | | | 24 |
| 2. need for safe, effective contraception | | | 27 |
| 3. problems with specific contraceptive methods: | | | |
| - DES | 4 | | |
| - IUDs | 7 | | |
| - Depo-Provera | 6 | | |
| - hormones, oral contraceptives | 4 | | |
| - surgery (ligation, sterilization) | 5 | | |
| 4. infertility | | | 10 |
| 5. reproductive technology re fertility | | | 15 |
| 6. access to abortion | | | 25 |
| 7. menopause | | | |
| - all references to menopause | | | 21 |
| - general references to menopause | 16 | | |
| - specific medical issues | 10 | | |
| o ERT, hormone use | | | 6 |
| o unnecessary hysterectomy | | | 8 |
| 8. concerns re menstruation | | | |
| - all references to menstruation | | | 10 |
| - general references | 2 | | |
| - premenstrual syndrome | 8 | | |
| 9. teen pregnancy | | | 15 |

D. Reproductive Disorders

| | | | |
|---|---|---|---|
| - sexually transmitted diseases | | | |
| o all references to STDs | | 11 | |
| o general references to STDs | 6 | | |
| o chlamydia | 4 | | |
| o AIDS | 4 | | |
| o herpes | 1 | | |
| - PID (also PID - related infertility) | | | 9 |
| - endometriosis | | | 3 |
| - vaginal infections | | | 3 |

E. Occupational and Environmental Health

1. Occupational health problems

| | | |
|---|---|---|
| - all references to occupational health | | 20 |
| - physical health and safety | 18 | |
| - workplace pressure | 8 | |
| - sexual harassment | 5 | |
| - reproduction issues | 2 | |

2. environmental health problems 15

F. Nutrition and Fitness

| | | |
|---|---|---|
| - all nutrition/fitness issues | | 17 |
| o inadequate diets | 10 | |
| o obesity | 5 | |
| o problems re dieting for weight control | 2 | |
| o lack of exercise | 9 | |

G. Chronic Medical Conditions

| | |
|---|---|
| - breast cancer | 3 |
| - other breast health issues | 3 |
| - other cancer | 3 |
| - arthritis, rheumatism | 2 |
| - osteoporosis | 5 |
| - psychiatric illness | 2 |
| - scoliosis | 2 |
| - diabetes | 1 |
| - allergies | 1 |
| - high blood pressure | 1 |

## TABLE II: FACTORS UNDERLYING WOMEN'S HEALTH ISSUES

### A. Attitudes and Practices of Medical Institutions

#### 1. Medical attitudes to women

| | | |
|---|---|---|
| - general references to harmful attitudes | | 20 |
| - women's competence re health not recognized | | 12 |
| o dependence on medical system encouraged | | 6 |
| - women's lifestages seen as medical problems | | 11 |
| - doctors insensitive to women's needs | | 9 |
| - social problems of women medicalized | | 8 |
| - males considered normal, standard | | 8 |
| - treatment of women different from men | | |
| o not taken seriously, considered neurotic | 6 | |
| o treatment different for certain conditions | 4 | |
| o medical focus on women's reproductive function | 2 | |
| - medical training, drug companies, medical literature, perpetuate these attitudes | | 12 |
| - lack of understanding of women's sexuality | | 3 |

#### 2. Medical control of/intervention in healthy processes

| | | |
|---|---|---|
| - all references re interventions | | 20 |
| o general references to medical intervention | 9 | |
| o medical intervention in reproductive lifestages** | 8 | |
| o medical control of childbirth* | 10 | |
| o intervention in contraception | 6 | |
| - women's lack of control and powerlessness regarding medical care. | | 15 |

* see also medicalization of childbirth as an issue, Table I
** see also specific medical interventions in menopause as issues, Table I

3. Medical focus on technology in research, prevention and treatment

| | | |
|---|---|---|
| - all references to focus on technology | | 29 |
| - general references to technology focus | 10 | |
| - overprescription of drugs | 16 | |
| - unnecessary surgery* | 5 | |
| - technology related to procreation: | | |
| o in contraception** | 7 | |
| o in childbirth*** | 3 | |
| o in fertility**** | 6 | |
| - lack of medical interest in prevention, focus on disease | 9 | |
| - lack of medical interest in nutrition | 4 | |

B. Access to Appropriate Medical and Health Services

1. Barriers to traditional medical services

| | | |
|---|---|---|
| - all references to barriers | | 25 |
| - general references to barriers | 5 | |
| - geographic (transportation) | 9 | |
| - financial | 8 | |
| - cultural/language | 4 | |
| - legislative/political/administrative barriers | | |
| o all references to these barriers | | 19 |
| o abortion services | 14 | |
| o teen contraception | 4 | |
| o reproductive care | 2 | |
| o STD clinics | 1 | |
| o fertility services | 1 | |

* see also contraceptive surgery, hysterectomy as issues, Table I
** see also contraception - specific medical concerns, plus need for safe, low technology methods as issues, Table I
*** see also medicalization of childbirth as an issue, Table I
**** see also reproductive technology as an issue, Table I

Table II: Factors Underlying Women's Health Issues (continued)

2. Lack of access to/availability of alternative health services*

| | | |
|---|---|---|
| - all references to alternatives | | 28 |
| - general references to alternative services | 19 | |
| - availability of women's health clinics | 4 | |
| - availability of alternative caregivers | 4 | |
| o insurance for alternatives | 1 | |
| - availability of birthing alternatives | | |
| o all references to birthing alternatives | | 16 |
| o general references to alternatives | 10 | |
| o birth centres | 2 | |
| o midwives | 14 | |
| o other reproduction issues | 1 | |
| - availability of alternative contraceptive service | 6 | |
| - availability of appropriate counselling services | 4 | |
| o addiction services | 1 | |

C. Women's Roles and Relationships

1. Attitudes to Women's Roles and Relationships

a) Attitudes undervaluing women's traditional roles

| | | |
|---|---|---|
| - all references to undervaluing | | 15 |
| - general references | 10 | |
| - low status of housewives, lack of recognition of work in the home | 11 | |
| - undervaluing of traditional women's employment | 6 | |
| - lack of recognition of unpaid community work | 3 | |

b) Stereotyping of women's roles and relationships

| | |
|---|---|
| i) Nature of stereotyping | |
| - prescriptive expectations of women's role in the home | 13 |

* see also changes needed re all these factors, Table VI-B

- o conflict for women: "traditional" vs "modern" role — 7
- o social powerlessness, dependence on men — 9
- o economic powerlessness, dependence on men — 10
- o social isolation of women at home — 13

- prescriptive expectations of women's employment, education — 10

ii) Processes maintaining stereotypes:

- socialization of girls towards dependence, subordination — 10
- reinforcement of stereotypes by systems and organizations
  - o education system reinforcing negative images — 5
  - o mass media images supporting stereotypes — 8
  - o religious, conservative groups working to maintain restrictive attitudes — 6

c) <u>Harmful attitudes and practices related to women's sexuality</u>

- all references to attitudes to sexuality — 12
- general references to harmful attitudes — 6
- prescriptive attitudes to women's sexual expression
  - o all references to prescriptive attitudes — 4
  - o general references — 2
  - o sexual availability expected — 2
  - o homophobia — 1
- attitudes and practices regarding women's bodies
  - o all references — 10
  - o general references — 4
  - o media exploitation — 2
  - o pornography — 5

2. Nature of Women's Roles

a) Responsibility load

| | | |
|---|---|---|
| - general references to heavy responsibility levels | | 2 |
| - responsibility for child raising | | 21 |
| - caregiver responsibility for family and others - physical and mental health | | 20 |
| o coping with family members' problems | 5 | |
| o handling family breakup | 5 | |
| - double workloads of employed women | | 15 |

b) Lack of support for women's roles

| | |
|---|---|
| - general references to lack of support | 7 |
| - lack of affordable day care | 17 |
| - inadequate social service support for caregiving at home | 9 |
| - lack of community and social support for women at home | 5 |
| - workplace conditions/benefits failing to recognize family responsibilities | 4 |

D. Economic Status of Women

1. Poverty and economic insecurity

| | |
|---|---|
| - references to poverty | 30 |
| - sources of poverty and insecurity: | |
| o low pay, inadequate benefits | 13 |
| o inadequate income support for poor families | 4 |
| o inadequate pensions for women | 2 |
| o marginality of women's jobs: unemployment, part-time work | 13 |
| o family law: unfair provisions and inadequate inforcement | 3 |

E. Occupational and Environmental Conditions

1. Negative social factors in the workplace

| | |
|---|---|
| - discrimination against women at work (unequal access to jobs, training, promotion; unequal pay) | 12 |
| - lack of job satisfaction | |

| | | |
|---|---|---|
| o general references to lack of satisfaction | 3 | |
| o powerlessness, exclusion from decision making | 8 | |
| o underemployment of women | 3 | |
| - workplace pressure/stress | 10 | |
| - sexual harassment | 5 | |

2. Unhealthy physical work situations

| | | |
|---|---|---|
| - all references to physical work environment | | 19 |
| - general references | 18 | |
| - pollution/contamination | 6 | |
| - tobacco smoke | 2 | |
| - sealed buildings | 1 | |

3. Unhealthy physical living environments

| | | |
|---|---|---|
| - all references to physical environment | | 15 |
| - safety of food | 5 | |
| - safety of products | 3 | |
| - environmental pollution | 10 | |

TABLE III: GROUPS AT SPECIAL RISK

| Group | Number of Informants |
|---|---|
| **A. Age Groups** | |
| 1. Teenagers and Young Women | 20 |
| 2. Midlife Women | 12 |
| 3. Elderly Women | 25 |
| **B. Economic Groups** | |
| 1. Poor Women (includes single parents, blue collar workers) | 24 |
| **C. Ethnic Groups** | |
| 1. Immigrant and Minority Women | 22 |
| 2. Native Women | 19 |
| **D. Geographic Groups** | |
| 1. Isolated and Rural Women | 14 |
| **E. Special Groups** | |
| 1. Disabled Women | 15 |
| **F. Others Groups** | |
| 1. Low Literacy Women | 8 |
| 2. Housewives | 5 |
| 3. Lesbian Women | 4 |
| 4. Post-psychiatric Patients | 3 |
| 5. Incarcerated Women | 2 |
| 6. Mentally Retarded Women | 1 |

## TABLE IV: VULNERABLE GROUPS: KEY HEALTH ISSUES AND UNDERLYING FACTORS

| A. Age Groups | Health Issues | | Factors | |
|---|---|---|---|---|
| 1. Teenagers and Young Women (N=20) | **Reproductive Health and Reproductive Disorders** | | - access to contraception | 2 |
| | - teen pregnancy | 15 | - access to sex education | 2 |
| | - contraception | 4 | - peer pressure | 2 |
| | - STDs | 4 | - role conflicts | 2 |
| | - access to abortion | 2 | - lack of direction | 2 |
| | **Mental Health** | 9 | | |
| | - general | 2 | | |
| | - sexuality | 4 | | |
| | - body image | 2 | | |
| | - self-esteem | 2 | | |
| | - eating disorders | 1 | | |
| | **Substance Use** | 6 | | |
| | - alcohol | 4 | | |
| | - tobacco | 4 | | |
| | - drugs | 2 | | |
| 2. Midlife Women (N=12) | **Menopause Problems** | 6 | **Medical System** | |
| | - estrogen replacement | 2 | - medicalization of menopause | 4 |
| | **Mental Health** | 7 | - medical attitudes to menopause | 4 |
| | - stress | 3 | - overprescription of drugs | 2 |
| | - depression | 3 | **Women's Roles** | |
| | - self-esteem | 1 | - social attitudes to midlife women | 6 |
| | - sexuality | 1 | - family responsibility | 4 |
| | - alcohol | 2 | - family changes | 4 |
| | | | - loneliness | 2 |

Table IV : Vulnerable Groups: Health Issues and Underlying Factors (cont'd)

| Age Groups | Health Issues | | Factors | |
|---|---|---|---|---|
| | | | **Economic Situation** | |
| | | | - poverty/economic dependence | 2 |
| | | | **Workplace Factors** | |
| | | | - discrimination at work | 2 |
| 3. Elderly Women (N=25) | **Mental Health** | 10 | **Social Factors** | |
| | - general | 4 | - isolation/loneliness | 13 |
| | - stress | 4 | - social attitudes to aging | 10 |
| | - depression | 1 | - fear of dependence | 3 |
| | - alcohol | 1 | - loss of friends/spouse | 2 |
| | **Nutrition/Fitness** | 4 | **Medical System** | |
| | - nutrition | 4 | - overprescription of drugs | 10 |
| | - fitness | 2 | - medical attitudes to aging | 4 |
| | **Chronic Conditions** | | **Economic Factors** | |
| | - frailty | 3 | - poverty | 6 |
| | - visual/hearing problems | 2 | - poor housing | 3 |
| | - foot problems | 1 | | |

Table IV : Vulnerable Groups: Health Issues and Underlying Factors (cont'd)

| B. Economic Groups | Health Issues | | | Factors | |
|---|---|---|---|---|---|
| 1. Poor Women | Mental health | | 9 | - poverty: access to basic goods/services | all |
| (includes single parents, blue collar workers) (N=24) | - general | 2 | | - access to medical services | 6 |
| | - stress | 8 | | - overwork/parenting responsibility | 6 |
| | - self-esteem | 2 | | - work pressure | 3 |
| | - depression | 1 | | - pollution: workplace and environment | 4 |
| | - alcohol/tobacco | 2 | | | |
| | Nutrition/Fitness | | | | |
| | - poor nutrition | 9 | | | |
| | - obesity | 3 | | | |
| | Work-related | | 6 | | |
| | - fatigue | 3 | | | |
| | - back problems | 2 | | | |
| | - others | 4 | | | |

Table IV : Vulnerable Groups: Health Issues and Underlying Factors (cont'd)

| C. Ethnic Groups | Health Issues | | | Factors | |
|---|---|---|---|---|---|
| 1. Immigrant and Minority Women (N=22) | Mental Health | | 4 | Medical System | |
| | - stress | 3 | | - medical attitudes | 5 |
| | - self-esteem | 2 | | - access to medical care | 3 |
| | - depression | 1 | | | |
| | - use of tranquillizers | 1 | | Social Factors | |
| | Family Violence | | 3 | - language barriers | 8 |
| | | | | - cultural conflicts, attitudes, alienation | 8 |
| | | | | - social attitudes to minorities | 4 |
| | | | | - isolation, powerlessness | 3 |
| | | | | Workplace Factors | |
| | | | | - work conditions | 4 |
| 2. Native Women* (N=19) | Mental health | | 2 | Access to medical services | 6 |
| | Substance use | | | Access to health/social services | 5 |
| | - alcohol abuse | 9 | | | |
| | - drug abuse | 4 | | - alternative health care | 2 |
| | | | | - support services | 2 |
| | Wife abuse | 6 | | - shelters | 1 |
| | | | | - addiction treatment | 1 |
| | Nutrition problems | | 3 | - midwives | 1 |
| | Teen pregnancy | | 2 | Access to basic goods/services | 4 |
| | | | | Social attitudes towards native women | 4 |

* Section on isolated/rural women is also relevant to this group

Table IV : Vulnerable Groups: Health Issues and Underlying Factors (cont'd)

| D. Geographic Groups | Health Issues | | Factors | |
|---|---|---|---|---|
| 1. Isolated and Rural Women (N=14) | Mental Health | 6 | Access to medical services | 8 |
| | - stress | 6 | - confidentiality | 2 |
| | - depression | 2 | | |
| | | | Access to health/social services | 12 |
| | Substance Use | | | |
| | - alcohol abuse | 4 | - alternative health care | 6 |
| | - drug abuse | 3 | - social services | 5 |
| | | | - day care | 4 |
| | Wife abuse | 3 | - midwives | 2 |
| | | | - birthing services | 1 |
| | | | - shelters | 1 |
| | | | - other services/resources | 2 |
| | | | Women's Roles | |
| | | | - isolation at home | 6 |
| | | | - powerlessness | 3 |
| | | | - responsibility overload for farm women | 2 |
| | | | Economic crisis in agriculture | 4 |
| | | | Transportation | 4 |

Table IV : Vulnerable Groups: Health Issues and Underlying Factors (cont'd)

| E. Special Groups | Health Issues | | | Factors | |
|---|---|---|---|---|---|
| 1. Disabled Women (N=15) | Mental Health | | 6 | Medical System | |
| | - stress | 3 | | - medical attitudes | 6 |
| | - sexuality | 2 | | - inappropriate care | 5 |
| | - depression | 1 | | | |
| | - substance use | 1 | | Social Factors | |
| | - general | 2 | | | |
| | | | | - social attitudes toward the disabled | 4 |
| | Violence | 2 | | - powerlessness, isolation, dependence | 2 |
| | Contraception | 2 | | | |
| | | | | Poverty/unemployment | 2 |
| | | | | Access | |
| | | | | - physical access to medical services, public places | 3 |
| | | | | - access to information | 1 |
| | | | | - availability of appropriate services | 2 |

Table IV : Vulnerable Groups: Health Issues and Underlying Factors (cont'd)

| F. Others Groups | Key Issues and Factors | Factors |
|---|---|---|
| 1. Low Literacy Women (N=8) | - access to medical care, information | 5 |
| 2. Housewives (N=5) | - isolation | 4 |
| | - stress | 2 |
| 3. Lesbian Women (N=4) | - social, medical attitudes | 3 |
| | - appropriate services | 1 |
| | - mental health/sexuality | 2 |
| 4. Post-psychiatric Patients (N=3) | - social attitudes | 1 |
| | - appropriate services | 2 |
| 5. Women in Prison (N=2) | - mental health | 1 |
| 6. Mentally Retarded Women (N=1) | - appropriate services | 1 |

TABLE V: POSITIVE FACTORS THAT FACILITATE HEALTH

| | |
|---|---|
| **1. Positive changes in societal attitudes and practices toward women** | |
| - increased sharing by/contact among women | 16 |
| - increased awareness of options and choices for and by women | 11 |
| - increased awareness and legitimization of women's issues | 8 |
| - increased recognition of women's culture and values | 6 |
| - increased recognition of and social policies supporting women's equality | 6 |
| - improved education opportunities for women | 2 |
| - improved media images of women | 2 |
| **2. Trend towards self-help and self-care in health** | |
| - increased interest in self-help and self-care | 10 |
| - increased knowledge of their own health | 10 |
| - increased questioning by women of medical system factors affecting their health | 5 |
| - increased awareness about lifestyles and health | 5 |
| - increased availability of health information in the media | 4 |
| **3. Growth of women's organizations and activities** | |
| - feminism and the women's health movement | 17 |
| - women's health collectives and networks | 12 |
| - women's self-help groups | 8 |
| - women's clubs, drop-in centres | 5 |
| - other references to women's organizations | 4 |
| **4. Improved medical care and alternative health services** | |
| - general references to improved care | 3 |
| - improved contraception | 8 |
| - establishment of women's health centres/ community clinics | 5 |
| - increased availability of alternative caregivers | 2 |
| - increased availability of abortion services | 2 |
| - positive changes around childbirth | 2 |
| - improved childbirth education | 2 |

5. **Health promotion programs and projects**

| | |
|---|---|
| - specific Health Promotion Directorate projects (in-house and contribution funded) | 5 |
| - PARTICIPaction program | 4 |
| - anti-smoking campaigns | 4 |
| - workplace health promotion programs | 2 |

6. **Improved social services**

| | |
|---|---|
| - examples include day care, shelters, immigrant services, services for disabled, etc. | 7 |

7. **Improved social conditions**

| | |
|---|---|
| - all references to social conditions | 3 |

TABLE VI-A: CHANGES AND PRIORITIES: HEALTH PROGRAMS AND PROJECTS

1. Policies for Health Programs for Women

| | |
|---|---|
| - change focus of programs towards prevention, promotion and wellness, and away from medicine, treatment and illness | 19 |
| - give priority to empowering people toward self-responsibility for health, self-help and self-care | 18 |
| - increase focus on activities by women for women, to meet women's real needs | 10 |
| - reorient programs towards a holistic view of health that includes social context | 5 |
| - give priority to eliminating barriers to health programs, including financial, social, cultural, geographic and physical barriers | -- |

2. Strategies for Effective Programs for Women's Health

| | |
|---|---|
| - stable funding: provide long-term, core funding for women's groups and women's health projects | 14 |
| - consumer input: involve women and relevant women's groups in health planning at all stages of program development | 12 |
| - provincial involvement: pressure provinces to adopt policies, strategies and activities that are consistent with those being recommended | 10 |
| - dissemination: give priority to dissemination and sharing of effective programs and approaches | 10 |
| - consumerism: give priority to approaches that encourage women to be better consumers of medical and health care | 9 |
| - community development: support community-based grassroots groups and programs with a community development approach | 9 |

- advocacy groups: adopt a position to support women's advocacy groups and other lobby organizations that are working for positive changes for women — 7

    - o support programs and groups with a feminist approach — 5

- Health and Welfare activities: strengthen the role of the Department in promoting women's health: — 3

    - o establish and give priority to a strong women's program within Health Promotion Directorate — 6
    - o improve communication with the public about Health Promotion Directorate activities — 5
    - o increase the Health Promotion Directorate Contribution Fund — 5
    - o expand the variety of women's groups eligible for Health Promotion Directorate contributions — 2
    - o decentralize the Health Promotion Directorate program — 2

- mass media: increase the use of mass media for health education for women — 7

- existing groups: work through established groups and networks — 4

3. Kinds of Programs

- health information: programs and projects that increase access to and availability of health information for women — 19

    - o special information programs for low literacy women — 6

- self-help groups: programs supporting and funding women's self-help groups — 18

- appropriate resource materials: development of resource materials on health appropriate for different groups of women — 13

- networks and exchange: supporting women's networking projects and information-sharing activities — 7

- other kinds of programs and projects:

| | |
|---|---|
| o skills development for group facilitators | 4 |
| o development of self-help materials | 3 |
| o travelling/outreach projects | 3 |
| o worksite projects | 2 |
| o films on women's health | 2 |
| o regional conferences, seminars | 2 |
| o health education in schools | 1 |

- programs and projects for special groups:

  - o rural, isolated women
  - o immigrants
  - o disabled

4. Specific Programs and Projects Needed

a) Topics requiring increased program attention

| | | |
|---|---|---|
| - medical system: skills and knowledge for dealing with medical system | | 10 |
| - sexuality | | 9 |
| - reproductive health and reproductive disorders | | |
| o all references | | 14 |
| o general references to need for programs | 2 | |
| o contraception | 5 | |
| o reproduction technology | 5 | |
| o STDs | 6 | |
| o pregnancy | 3 | |
| o menopause | 3 | |
| o fertility | 1 | |
| o DES | 1 | |
| - parenting: information and resources for parents | | 6 |
| - other topics | | |
| o fitness | 3 | |
| o drugs, alcohol | 3 | |
| o how bodies work | 3 | |
| o mental health | 3 | |
| o nutrition | 2 | |
| o aging | 2 | |
| o breast self-examination | 2 | |

b) Special projects needed, all topics

- national women's health network 14

- national, regional clearing houses on women's health 10

- national non-governmental watchdog/lobby group on women's health and social issues 2

- regional information telephone lines (800 system) on women's health and social issues 4

c) Innovative programs and project ideas

- programs on women's health using the technology and distribution system of the video industry

- projects to counter directly and quickly media misinformation

- information programs for women on relevant legislation and regulations, and how to use them

- approaches using shopping malls and storefront operations as accessible women's health resource centres

TABLE VI-B: CHANGES AND PRIORITIES: MEDICAL AND HEALTH SERVICES

1. Policies for Health and Medical Services for Women

a) Appropriate Services

| | | |
|---|---|---|
| - give priority to developing and ensuring access to alternative health services and practitioners for women | | 35 |
| - give priority to eliminating barriers to traditional medical services, including financial, social, cultural, geographic and physical barriers | | |

b) Medical Attitudes and Practices

| | | |
|---|---|---|
| - recognize the need to reduce medical power and control of services and to increase consumer control | | 16 |
| - change the focus of the medical system towards prevention and caring and away from high technology interventions | | 16 |
| - recognize the need for positive changes in medical attitudes to women | | 7 |

2. Strategies for Effective Health and Medical Services for Women

| | | |
|---|---|---|
| - recognize, legitimize and fund alternative health services and practitioners | | |
| o all references to alternative systems | | 26 |
| o general references to support for alternatives | 19 | |
| o institute health insurance funding for alternatives | 14 | |
| - establish traditional and alternative services for special groups | | |
| o all references | | 21 |
| o establish services in rural and remote areas | 9 | |
| o establish services, train practitioners for minority (12), disabled (15), elderly (3) women | | |

- pressure provinces to support changes in services consistent with those being recommended — 10

- support education for doctors, re prevention, women's health, community services, etc. — 10

- encourage increasing involvement of women as health practitioners in all aspects of health and medical care — 9

- ban extra-billing — 7

- involve women as consumers of health services in planning at all stages of service development — 5

- institute health insurance for prevention activities by doctors — 4

3. Specific Health and Medical Services Needed

- access to abortion services for all women — 26

- alternative birthing services — 20

  - o all references
  - o general references to birthing services — 8
  - o midwives — 16
  - o birth centres — 4

- women's health centres — 15

- services related to sexual activity (teens and others) — 10

  - o all references
  - o birth control — 6
  - o sexuality — 3
  - o STDs — 3

- addiction treatment services for women — 8

- services dealing with violence against women — 8

- counselling services for women — 6

- community clinics for medical care — 6

TABLE VI-C: CHANGES AND PRIORITIES: SOCIAL AND ECONOMIC POLICY

| | | |
|---|---|---|
| - ensure access to quality child care | | 15 |
| - adopt economic policies that lead to economic security for women | | |
| o all references | | 14 |
| o general references | 4 | |
| o income support for families | 6 | |
| o guaranteed minimum wage | 4 | |
| o adequate pensions for women | 3 | |
| - increase commitment to improved work benefits for all, which recognize parental roles and family responsibilities | | 8 |
| - increase priority for social services supporting women in their caregiving roles | | 8 |
| - adopt policies recognizing and supporting women's work in the home | | 7 |
| - enforce policies leading to safe and healthy environmental and workplace conditions | | 7 |
| - adopt policies supporting equality of women in the workplace | | 6 |
| - adopt policies supporting the integration of disabled, immigrant, minority and other special groups of women | | 6 |
| - ensure access to essential basic goods and services, including affordable nutritious food in remote areas | | 4 |
| - ensure access to appropriate housing for all | | 3 |

## TABLE VI-D: CHANGES AND PRIORITIES: RESEARCH

1. Policies on Research

| | |
|---|---|
| - increase focus on women's health and health needs | 8 |
| - support research on women by women | 6 |
| - seek consumer input on research funding decisions | 4 |
| - publicize research findings about women's health issues | 3 |

2. Specific Research Needs

Issues Identified as Research Needs

| | |
|---|---|
| - safe, low technology contraception | 7 |
| - causes and prevention of infertility | 5 |
| - consequences of new reproductive technologies | 3 |
| - long-term effects of Depo-Provera | 3 |
| - sexually transmitted diseases | 3 |
| - health and safety risks in traditional women's work | 2 |

TABLE VI-E: CHANGES AND PRIORITIES: REGULATIONS AND LEGISLATION

1. Policy on Regulations and Legislation

| | |
|---|---|
| - seek consumer input in working groups and on planning committees for regulations and legislation affecting women's health | 6 |

2. Specific Changes Needed in Regulations and Legislation

| | |
|---|---|
| - liberalization of abortion laws to ensure access for all women | 11 |
| - modification of laws and regulations to allow the practice of midwifery | 7 |
| - strengthen regulations for testing of drugs, devices and other products, including monitoring and retesting of those currently on the market | 6 |
| - strengthen regulations on and enforcement of health and safety in the workplace | 4 |
| - introduce regulations controlling the development of new reproduction technologies | 3 |
| - regulations controlling media images and exploitation of women | 3 |
| - strengthen and increase enforcement of environmental protection laws | 2 |
| - strengthen and increase enforcement of laws protecting women from assault | 2 |